

## GOVERNMENT OF THE DISTRICT OF COLUMBIA OFFICE OF RISK MANAGEMENT



Jed Ross Chief Risk Officer **Public Sector Workers' Compensation Program** 

## Form 13 - REQUEST FOR WAIVER OR CHALLENGE OF PRELIMINARY DECISION ON OVERPAYMENT

## READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE

Use this form to challenge or request for waiver of the Public Sector Workers' Compensation Program's (PSWCP's) Preliminary Determination of Overpayment ("Preliminary Determination") pursuant to D.C. Code § 1-623.29 and 7 D.C.M.R. 3333.

**SUBMISSION DEADLINE:** Your request or waiver of or challenge to the Preliminary Determination must be received by the Office of Risk Management (ORM) within **thirty** (30) calendar days, from the date that the PSWCP issued the Preliminary Determination. If the calendar-day filing deadline falls on a Saturday, Sunday, or a legal holiday, the deadline is extended to the next business day ORM is open.

Please submit <u>with this form</u> a copy of the Preliminary Determination and any necessary attachments. This request, excluding supporting documentation, shall not exceed 10 pages.

CLA	IMANT INFORMATION		
Claimant's Name:		Representative (if any):	
Claimant's Full Address (with unit number, zip code):		Rep.'s Full Address (with unit number, zip code):	
Claimant's Telephone: Claimant's E-mail: Claim Number: Employing Agency:  Date of Notice of Preliminary Determinary		Rep.'s Telephone: Rep.'s Fax: Rep.'s E-mail Date of Injury:	
REA	SON – CHECK ALL THAT APPLY		
	I request a waiver of the adjustment or recovery because it will result in severe financial hardship. (If you check this box, please complete and attach Form 13F – Financial Statement Form and attach records, proof, or evidence in support of your position).		
	I challenge the PSWCP's preliminary finding of additional paper if necessary. Attach records, proof, or evide	f fault against me. (Please explain your position below. Use ence in support of your position.)	
	→ → TURN OVE	R TO CONTINUE → →	

I challenge the fact of necessary. Attach record	r amount of the overpayment. (Please explain your pods, proof, or evidence in support of your position.)	osition below. Use additional paper if
a wood this Forms	I away on offine that the contents are town	d convents to the best of mer
e read this Form and ledge.	l I swear or affirm that the contents are true and	a accurate to the best of my
Jame	Signature	Date

<u>WHERE TO FILE</u>: Return this form to **ORM/PSWCP by mail, in person, e-mail, or fax**. You may return the form in person, weekdays between 8:30 a.m. and 5:00 p.m. You will need photo identification to enter the building:

Office of Risk Management One Judiciary Square 441 Fourth Street, NW, Suite 800 South Washington, D.C. 20001 Phone: (202) 442-HELP (4357)

E-mail: wcsecure@dc.gov Fax: (202) 535-1130

Please visit http://www.orm.dc.gov for more information.

This form must be received by ORM no later than the 30<sup>th</sup> day after the Date of the Notice of Preliminary Determination of Overpayment. If this form is forwarded by mail, there is no guarantee that it will be received by ORM within 30 days.